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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNY LOUISE HURST** **211 State College Blvd. #183** **Anaheim, CA 92806** **Registered Nurse License No. 430190** Respondent.	Case No. 2013-424 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1988, the Board of Registered Nursing issued Registered Nurse License Number 430190 to Jenny Louise Hurst (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

8. Title 16, California Code of Regulations, section 1443, provides:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, California Code of Regulations, section 1443.5, provides:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

11. Respondent was employed as a registered nurse at Western Medical Center Anaheim (WMCA) in the Medical/Surgical/Telemetry Unit 4 (MSTU).

12. On April 2, 2009, a 66 year old female patient (Patient A) was admitted to WMCA for a non-interventional heart catheterization. Patient A had an extensive medical history, including coronary artery disease (CAD); status post myocardial infarction (heart attack) x 2 in 2001 and 2007; status post coronary artery bypass graft (CABG) x 5 in 2007; hypertension (HTN); insulin-dependent diabetes mellitus (IDDM); peripheral vascular disease (PVD); morbid obesity; hyperlipidemia; end-stage renal disease (ESRD) and on dialysis for the past year and a half; and recent cardiopulmonary arrest on March 26, 2009, with subsequent stabilization and hospitalization for one week at another facility.

13. Patient A was transported to the Cath Lab for the heart catheterization procedure. Patient A's vital signs and EKG throughout the heart catheterization procedure were stable at all times. Patient A received 3 mg of Morphine (IVP) and 1 mg of Versed (IVP) during the procedure at 1555 hours. Patient A's vital signs were completed in the Cath Lab at 1615 hours on April 2, 2009.[1] Following the heart catheterization, Patient A was transferred at approximately 1618 hours on April 2, 2009 via gurney from the Cath Lab to MSTU on a cardiac monitor accompanied by another nurse. Patient A's care plan was for her to be monitored post-operatively and medically managed per her cardiologist's recommendation.

14. Respondent was assigned to care for Patient A in the MSTU on April 2, 2009. Respondent received and assumed care of Patient A but failed to document Patient A's time of arrival in the MSTU. Respondent failed to document, or failed to perform, her initial assessment and Patient A's vital signs.[2] Respondent failed to fully document, or failed to perform, a

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[1] Patient A's vital signs were recorded as follows: "SpO2 97%; HR 74bpm; 145/89 NBP; RR 34/min." Patient's pain recorded at 1615 hours read: "Pain scale 0-10:0." Last method of oxygen deliver was recorded pre-procedure at 1547 hours: "O2 ON PT: 2LPM/NC." Last glucose recorded at 1537 hours as "255." The laboratory documentation reflect that this blood draw was taken at 1352 hours.

[2] Respondent documented vital signs as "stable" but provided no numerical values for identification of the "stable" vital signs.

thorough "head to toe" exam, including respiratory effort, lung sounds, mode of oxygen deliver, skin signs and whether there was bruit and thrill assessed to Patient A's dialysis fistula. Respondent failed to document, or failed to obtain a blood glucose reading. Although Patient A was transported from the Cath Lab on a cardiac monitor and had an extensive cardiac history, Respondent failed to place Patient A on a continuous cardiac monitor immediately upon arrival to the room and prior to medicating her. Respondent did not document, or failed to perform, continuous pulse oximetry readings and an EKG tracing strip was not recorded until 1755 hours.

15. On April 2, 2009 at 1730 hours, Respondent administered .5 mg of Dilaudid (IVP) to Patient A. Respondent did not record vital signs or respiratory status prior to administering the Dilaudid. Respondent did not check on Patient A again until twenty-five minutes later at 1755 hours. At 1755 hours, the patient was found unconscious, apneic, cyanotic and a code blue was called.[3] Patient A was then placed on a cardiac monitor, intubated and transferred to ICU where Patient A remained comatose until her death two days later on April 4, 2009.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence)

16. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her employment at WMCA, Respondent demonstrated incompetence in her care of Patient A, as she failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse, as is set forth in paragraphs 11 through 15 above, as follows:

a. Respondent failed to document the time she received and assumed care of Patient A, a post operative/heart catheterization patient. Respondent also failed to record admitting vital signs, a complete systems assessment, and finger stick blood glucose test.

b. Respondent failed to record, or failed to perform, every 15 minute vital signs and assessments on Patient A. Respondent also failed to document any vital signs until the code blue

[3] No vital signs were documented on any of the nursing documentation for Patient A until the code blue was initiated.

was initiated. Respondent failed to place Patient A on a cardiac monitor and failed to document the Patient A's heart rhythm or oxygenation until after the code blue was initiated.

c. Respondent administered Dilaudid to Patient A without documenting assessment of vital signs, lung sounds, respiratory effort/quality, oxygen saturation, cardiac monitor activity, assessment for adverse side effects, pain relief, patient's mental status, and skin color/temperature/moisture prior to or soon after administering the medication. Respondent also failed to safely monitor Patient A.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 430190, issued to Jenny Louise Hurst;

2. Ordering Jenny Louise Hurst to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: November 27, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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